

# INVOICE FOR MONTH OF October 2015 (BUDGET-BASED GRANTS & CONTRACTS)

Please provide written notification of any change in address or contact person to the division or office representative.

Electronic Funds Transfer (EFT)? ☒ Yes (Must have completed authorization agreement for EFT on file.)

☐ No EFT agreement

Remit checks or remittance advise to:

CONTRACT NUMBER:	<b>40500-044-15151475</b>
CONTRACTOR:	Columbus Wellness Center Outreach & Prevention Project, Inc.
Attention:	Luella L. Rhodes, PA
Mailing Address:	1220 Wildwood Avenue Columbus Georgia 31906
Telephone:	706-596-1171
Contractor's Invoice Number:	<b>1</b>
Name of contract monitor:	Rhonda Simpson
Contract monitor's telephone:	404-463-0389

MAIL ORIGINAL SIGNED INVOICE TO: GEORGIA DEPARTMENT OF PUBLIC HEALTH  
PO BOX 1956  
ATLANTA GA 30301

	(A)	(B)	(C)	(D)
Expense Category	Approved Budget for Entire Grant or Contract	Prior Cumulative Expenditures	Billing This Current Period	Balance of Funds Remaining Unspent
A. Personal Services	<b>100,000.00</b>		<b>8,000.00</b>	0
B. Fringe Benefits	<b>11,200.00</b>		<b>1030.00</b>	<b>0</b>
B. Supplies Postage	<b>3,000.00</b>		<b>500.00</b>	0
C. Travel	<b>2,000.00</b>			0
D. Equipment				0
E. Facility Costs	<b>14,000.00</b>		<b>1,250.00</b>	0
F. Per Diem / Fees / Contracts	<b>2,800.00</b>		<b>100.00</b>	0
G. Telecommunications/Internet	<b>2,400</b>		<b>200.00</b>	0
H. Other (Specify)	<b>5,000</b>			0
Liability Participant Awards				
Indirect Admin Fee: <small>MAXIMUM 9.27% OF TOTAL BUDGET</small>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>TOTAL</b>	<b>\$150,000</b>		<b>11,080.00</b>	<b>0</b>

I, the undersigned, certify that the services or products shown above have been provided according to the terms of the contract and that the payment amount claimed accurately reflects the contracted rate.

**Luella L. Rhodes, PA**

Contractor signature

October 8, 2015

Date submitted to Division

Approved for Payment:

\_\_\_\_\_  
Signature of DPH program officer (contract monitor)

\_\_\_\_\_, District Liaison, 12TH floor, cubicle # \_\_\_\_\_

Tel \_\_\_\_\_

HIV Unit, Division of Public Health

Printed name, cubicle number and phone of DPH program officer

\_\_\_\_\_  
Date received

\_\_\_\_\_  
Date approved

# INVOICE FOR MONTH OF **October 2015** (FEE-FOR-SERVICE GRANTS & CONTRACTS)

*Please provide written notification of any change in address or contact person to the division or office representative.*

**Electronic Funds Transfer (EFT)?** ☒ **Yes** (Must have completed authorization agreement for EFT on file.)  
☐ **No EFT agreement**

**Remit checks or remittance advise to:**

<b>CONTRACT NUMBER:</b>	<b>40500-044-15151475</b>
<b>CONTRACTOR:</b>	<b>Columbus Wellness Center Outreach &amp; Prevention Project, Inc.</b>
<b>Attention:</b>	<b>Luella L. Rhodes, PA</b>
<b>Mailing Address:</b>	<b>1220 Wildwood Avenue Columbus Georgia 31906</b>
<b>Telephone:</b>	<b>706-596-1171</b>
<b>Contractor's Invoice Number:</b>	<b>1</b>
<b>Name of contract monitor:</b>	<b>Rhonda Simpson</b>
<b>Contract monitor's telephone:</b>	<b>404-463-0389</b>

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\*Attach additional sheets if needed. List each item separately. Provide full date for each item.

<b>Dates of Service</b>	<b>Description of Accomplishments</b> Including intervention name, number of clients and site location	<b>Unit Cost</b>	<b>Amount</b>
10/1-31/2015	Muscogee County Evidence Based Aban Aya Implementation Family Centered Adolescent Development Education Organization, Preparation for Community Forum		\$11,080
<b>TOTAL=</b>			<b>\$11,080</b>

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**Luella L. Rhodes, PA**

*Contractor signature*

**October 8, 2015**

*Date submitted to Division*

*Approved for Payment:*

\_\_\_\_\_  
*Signature of DPH program officer (contract monitor)*

\_\_\_\_\_, District Liaison, 12TH floor, cubicle # \_\_\_\_\_  
 Tel \_\_\_\_\_

HIV Unit, Division of Public Health

*Printed name, cubicle number and phone of DPH program officer*

\_\_\_\_\_  
*Date received*

\_\_\_\_\_  
*Date approved*